1635 Prince Street, Alexandria, Virginia 22314-2818 Telephone: (703) 683-4646 Fax: (703) 683-4745

HELICOPTER ASSOCIATION INTERNATIONAL

TESTIMONY ON
OVERSIGHT OF HELICOPTER MEDICAL SERVICES

COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEE ON AVIATION
UNITED STATES HOUSE OF REPRESENTATIVES

April 22, 2009

Matthew Zuccaro
President

Dedicated to the advancement of the international helicopter community
www.rotor.com

HELICOPTER ASSOCIATION INTERNATIONAL

TESTIMONY ON
OVERSIGHT OF HELICOPTER MEDICAL SERVICES

HOUSE TRANSPORTATION AND INFRASTRUCTURE COMMITTEE
SUBCOMMITTEE ON AVIATION
UNITED STATES HOUSE OF REPRESENTATIVES

April 22, 2009

HAI sincerely appreciates the opportunity to address legislative proposals offered by Mr. Salazar (H.R. 1201) and Mr. Altmire (H.R. 978) and to discuss the oversight of helicopter medical services with the committee. I respectfully request that you accept my full written testimony into the official record.

HAI represents the international helicopter community and is a not-for-profit, professional trade association of over 2,800 members, inclusive of 1,400 companies and organizations. HAI members safely and professionally operate in excess of 5,000 helicopters, and fly more than two million flight hours per year.

Member companies include helicopter and heliport operators, as well as manufacturers, and unlike many other trade associations, operations conducted by HAI members are not limited to one type of specific flying or purpose. HAI members operate helicopters across a wide spectrum of over 50 missions, such as offshore oil and gas support in the Gulf of Mexico, on-demand charter, utility services, public service, law enforcement, and agricultural, as well as emergency medical services.

HAI represents 93 air medical service operators, providing service throughout the U.S. These operators are comprised of 74 commercial operators and 17 government service operators, flying a total of 1,219 aircraft, which we estimate represents 90 % of the helicopter EMS operations being conducted within the United States.

HAI believes the current emergency medical services (EMS) accident rate is unacceptable and that the recent series of events were preventable. We fully support any initiative that improves the safety of EMS operations, and recommend a cooperative effort between industry and FAA, with a resultant FAA rulemaking initiative as necessary to achieve a safer EMS industry. In recognition of this, HAI has worked with EMS operators to mitigate accidents, emphasizing risk management, and advocates for the extensive use of safety management systems (SMS). HAI has been instrumental in working closely with the FAA in the development of long-term initiatives addressing such issues as 135 vs. 91 operations on all legs, utilization of such technology as Night Vision Goggles, radar altimeters, HTAWS, devices that perform the

function of CVR/FDR, operational control centers, and formalized risk assessment/hazard mitigation programs.

HAI has also been an industry leader by sponsoring numerous Safety forums focused on helicopter EMS operations. Participation in these forums has involved industry as well as executive level representatives of the FAA and NTSB, all working towards our common goal of enhanced safety.

Additionally, HAI has committed resources and staff in support of the efforts of the International Helicopter Safety Team (IHST), a worldwide helicopter industry initiative with a goal of reducing helicopter accidents by 80% within the next 10 years. In addition to my position as President of HAI, I am also honored to serve as the Co-Chair of the IHST global effort, which is a data driven analysis process, modeled after the successful CAST program utilized by scheduled air carriers.

As a result of a recent in-depth collaborative industry / FAA safety effort, the FAA made revisions to Part 135 HEMS Operations Specifications (A021), setting forth detailed flight planning and increased weather minimum requirements for EMS helicopter flights. Additionally, the FAA is currently evaluating the use of single-crew night vision goggle (NVG) operations to determine safety benefits.

Of equal importance is the need to secure Federal funding for remote weather stations that would fill the existing gap, especially at night, in the availability of off-airport automated weather reporting stations to support helicopter EMS operations. There is also a critical need for a dedicated low-altitude IFR helicopter route structure, and associated instrument helicopter approaches to hospital heliports, and other locations such as accidents scenes. This will provide all-weather helicopter instrument flight capability emergency services in the public interest, which is consistent with public expectation and necessity of such services. Any funding initiative should be inclusive of research and development of advanced technologies to facilitate this capability.

Earlier this year, the National Transportation Safety Board (NTSB) completed four days of safety hearings on the subject of helicopter emergency medical services (EMS). HAI was a designated party to and witness at the NTSB hearings and continues to serve as a major contributor to the NTSB and FAA efforts to enhance safety in EMS operations. The use of helicopters to provide emergency air ambulance transport has a unique set of operational issues that are distinct from other helicopter operations. The recent NTSB public hearings on the matter dealt with and documented this aspect.

H. R. 1201, the Salazar legislation, aims to increase safety for crew and passengers on aircraft providing emergency medical services and would require EMS pilots to comply with Part 135 regulations whenever there is medical crew on board, regardless of whether a patient is also on board. Part 135 did not envision operations <u>not</u> being conducted from or to an airport. This has produced unique issues for helicopter operations due to an inherent belief that there is always weather support wherever operations are conducted.

While HAI supports the conduct of actual EMS under Part 135, requiring non- EMS operations under Part 135 on all legs does not address all of the safety concerns. While destination weather sources are required for Part 135 IFR, some relief has been provided with the revised EMS operations specification (A021) which allows for any weather source approved by the administrator within 15 miles of destination.

Relative to the discussion of Part 135 vs. 91 on all legs, based on the initial information regarding the recent fifteen (15) accidents / incidents involving HEMS helicopters within the last sixteen (16) months, it appears that none of the 15 accidents would have been affected by implementation of the Part 135 requirement contained within the Salazar bill.

HAI believes the actual question that should be addressed regarding medical personnel being onboard the aircraft relates to their status, as to whether they are passengers or crewmembers. Once a resolution is reached as to this issue, then the proper regulatory guidance can be applied, be that FAR Part 135 or 91. Should medical personnel be granted special status such as Part 135.85? Or should they be included in the definition of crew members and potentially be subject to such oversight as drug / alcohol screening and duty/rest requirements? Also, how do we address operations where everyone aboard the aircraft is a company employee and no patient is embarked (i.e. no common carriage)? Such a flight is legitimately allowed as a Part 91 operation. Currently, the question becomes an operator-by-operator decision. HAI believes Congress should task FAA with resolving this matter.

Further H.R. 1201 should be modified calling for the operator and not the pilot to comply with Part 135 regulations whenever medical personnel are on board, regardless of whether a patient is also on board. It is the operator that holds the Part 135 certification and not the pilot.

HAI is a strong advocate of flight risk evaluation, including usage of a standardized checklist of risk evaluation factors to determine whether a flight should be conducted. A collaborative effort between the FAA and the air medical community should be undertaken to develop performance-based flight dispatch procedures and a method to measure compliance. HAI recommends H.R. 1201 be revised to clarify that the performance based flight dispatch procedures should be for the dispatch of the aircraft and not the pilot.

An appropriate feasibility study should be conducted by the FAA Administrator on “devices that perform the function of recording voice communications and flight data information” on new and existing aircraft. The use of the words “flight data and cockpit voice recorders” contained in the Salazar bill does not give recognition to alternative technologies that better serve helicopter operations.

With regard to FAA rulemaking, HAI believes the current FAA rulemaking process is unacceptable in terms of the length of time it takes to effect a rule change. Clearly, the FAA rulemaking process is not timely, and needs to be revised. Accordingly, Congress should direct the FAA to review its current rulemaking procedures and revise same to expedite implementation of beneficial safety initiatives, when appropriate.

Mr. Altmire's legislation, H.R. 978, is asking for a change in existing law under the guise of health planning and patient safety to allow states to regulate aviation operations already covered by FAA regulations. The authority of states to regulate helicopter medical services with respect to medical qualifications and training already exists.

The Airline Deregulation Act (ADA) of 1978 stipulates that the Federal government shall have preemptive rights with regard to interstate air transportation, and prohibits air carriers from operating unless they are in compliance with Federal Aviation Regulations (FARs). Under the doctrine of implied or field preemption, concurrent state regulation is preempted even if it is not in conflict with federal law. Helicopter operators who provide aircraft for EMS are by definition (14 CFR Part 119.3) on demand charters and are required to be in full compliance with applicable FAA regulations, i.e. 14 CFR Part 135.

The FAA's certification branch is responsible for determining what equipment is appropriate and does not interfere with navigational equipment or aircraft systems – similarly, the aircraft cannot have equipment installed that would interfere with necessary medical equipment. The Department of Transportation (DOT) has concluded that a state is free to regulate medical services provided inside an EMS aircraft, including establishing minimum requirements for medical equipment as well as training and licensure requirements for the medical crew.

What the Altmire bill is really saying here is that the ADA doesn't apply to medical health-related regulations. Where is the deficiency? Is substandard medical service being delivered? Medical treatment has nothing to do with safety of aircraft. This is clearly not an aeronautical deficiency, but rather economic regulation, and would result in entry controls limiting who can conduct EMS operations on a state-by-state basis, thereby eliminating robust competition where so required in the public interest to provide air transportation to the greatest number of people.

What determines adequate capacity? What is a state's interpretation? What demonstrates the need for new or expanded helicopter medical services? If you are concerned with safety and getting people to a hospital safely, why would you limit the number of helicopters or the routes they can fly? Where is the direct correlation or research that indicates the number of HEMS accidents in a given area is directly related to the number of providers in that geographic area.

What if one EMS operator could only fly from D.C. to Fredericksburg and another could only fly from Fredericksburg to D.C. because of state imposed route mandates? Is such an operational constraint in the public interest?

What about the potential impact on other industry segments? Mr. Altmire's bill would lead the aviation industry and, in particular, the helicopter industry down a slippery slope. Other helicopter segments such as pipeline and power line patrol, aerial application, and air tours, where aircraft require the ability to routinely cross state lines to conduct operations could find themselves facing a myriad of conflicting regulations or the inability to operate in a neighboring state. It also opens the door to facilitating states' collecting more revenue from additional licensing requirements. There is no need to pass a remedy to fix a problem that doesn't exist.

Congress must not allow states to regulate aeronautical issues. Aviation services and medical services are separate and distinct, except for such issues as the installation of medical equipment within the aircraft which clearly falls under FAA purview as it pertains to airworthiness. As separate and distinct entities in the course of conducting EMS operations, the unanswered questions this legislation raises are how H.R. 978 will make EMS operations safer, what is the problem that will be fixed with passage of the Altmire bill, and what unintended consequences will result for all forms of aviation if H.R. 978 is approved?

The Altmire legislation would result in a patchwork of regulations wherein helicopter operators would have to meet aviation requirements at the Federal level for their certification, at the state level for essentially the right to operate, as well as the qualification of their medical personnel and equipment, thus potentially having to meet more than one state's requirements. If the nearest trauma center is 10 minutes away across a state line, should a state be able to say operators must fly 60 miles in the opposite direction to the nearest in-state trauma facility?

By the very nature of their geographic sphere of operations, EMS operators routinely cross state borders, and one aircraft could operate in three or more states over the course of one period of duty. The Department of Transportation (DOT) opined that as a practical matter, all air ambulance providers would likely be viewed as engaging in interstate commerce under applicable legal standards, even in a state the size of Texas. Further, DOT said that "permitting a state to impose its own rules would create bureaucratic redundancies, duplicative enforcement regimens, and potentially inconsistent interpretations and enforcement approaches."

States are already regulating medical or non-aviation aspects of EMS. For example, the states regulate the licensure of EMS organizations for various types of EMS tasks, as well as the training and certification of medical professionals, and continuing education requirements for medical providers.

Helicopter operators already coordinate with emergency medical service providers, receiving institutions, and other medical transport service providers. They deliver emergency helicopter medical services to all persons as medically necessary and appropriate in accordance with the helicopter providers' contracts. Operators do not determine who is to be transported; the medical community makes that decision.

The States already regulate vehicles used for EMS, including aircraft as relates to medical issues. For example, Virginia regulates the sanitation of vehicles, including aircraft used for EMS. Virginia regulations specify the medical equipment and supplies that must be carried on board, and requires that aircraft used for EMS have radios to allow communications among different EMS providers. (See 12 VAC 5-31-720, 840, and 760). On certification and safety of flight issues, the Virginia regulations defer to the FAA, distinguishing between medical care and flight safety, extensively regulating the former and deferring to the FAA as to the latter.

Where the state of Tennessee attempted to mandate certain avionics to be used in EMS helicopters, a federal court found as a matter of law that the Tennessee regulation went too far and was preempted by Federal law. Allowing states to interfere in aeronautical equipment carried on board or affixed to the helicopter crosses the line, and this is clearly mandated by the

FAA. Physical attributes and helicopter equipment must be consistent with federal operating requirements.

The purpose, history, and language of the Federal Aviation Act and the creation of the FAA demonstrate that Congress intended a single, uniform system in place to regulate aviation safety. As has been well documented in numerous court cases, states should not be free to undermine and render ineffective federal safety programs. Application of varying state laws to aviation safety issues would be a detriment, and result in an unreasonable patchwork of state laws governing airspace safety.

Through the Airline Deregulation Act (ADA), Congress deregulated the air transportation industry to ensure that the States would not undo Federal deregulation with regulation of their own, to prevent conflicts and inconsistent regulations, preempting any state laws relating to rates, routes or services of any air carrier. Thus, there is no need for the Altmire legislation to amend the preemption provisions as proposed, since the states are already regulating the medical aspect of EMS, and the states can do so without upsetting well-settled principles of preemption and the recognized need to have uniform regulation of airspace and air operations.